

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2025
NAME OF PROVIDER OR SUPPLIER Richland Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 900 East Scott Street Olney, IL 62450	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619</p> <p>Based on interview and record review, the facility failed to timely contact a residents Power of Attorney (POA) and provide a comprehensive report of an elopement for one resident (R1) of three residents reviewed for POA notification in the sample of three.</p> <p>Findings include:</p> <p>R1's Face Sheet documented an admitted [DATE] and listed Diagnoses including Alzheimer's Disease and Hypertensive Heart Disease with Heart Failure. R1's Minimum Data Set (MDS) dated [DATE] documented that R1 is severely cognitively impaired, wanders, and exhibits behaviors not directed toward others. The same MDS documents that R1 has no impairments in upper or lower body range of motion and requires partial to moderate assistance for walking. R1's Care Plan dated 4/16/25 documented a problem area, Resident is at risk for injuries due to exit seeking behaviors. Attempts to exit the building unattended, with corresponding interventions, Re-direct as needed/cues; Notify all staff of residents tendency to seek exits; Diversional activities as tolerated; Check residents whereabouts; Staff to Initiate 30 minute checks. A Power of Attorney (POA) for Health Care form dated 3/22/24 listed V11 as R1's POA.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Police Report dated 4/12/25 at 6:18pm documented, in part, On 4/12/25, I, (V6, Police Officer) was off-duty, when I viewed an older male sitting in the drivers seat of a (vehicle) (at a location 0.2 miles away from the facility) with what appeared to be blood coming from the left upper head area. As I went around the block to come back to the male subject, I called dispatch on what I viewed and kept them on the phone while I made contact with the male in the vehicle. Before approaching the vehicle, I gave the Illinois registration information to dispatch. Once at the vehicle, the male opened the drivers door, and I viewed scrapes on the palm of his right hand, skin tears that were open and bleeding, and a laceration on the outer left eyebrow area. I requested an ambulance come and check on the male, with dispatch toning out an ambulance to my location. At this time I hung up with dispatch and stayed with the male. While speaking with the male, I learned his name was (R1) and that he had fallen down in front of his vehicle. (R1) advised that he was just sitting in his car for a minute, but he was ready to go now. I viewed (R1) not to be responding correctly, and he did not seem to know where he was at. When I asked (R1) what his address was, he could not tell me and said that he lived on that street over there. I asked (R1) why he was out of his vehicle and how he fell down, he advised that he was working on a house and was going home now. At this time (R1) began reaching for the ignition, but I got his attention back to me advising him that I wanted him to get checked out by the medics before he goes home. (R1) then advised that this was ok, and began thanking me for stopping and helping him. I was then able to reach across the steering column and feel for ignition keys, but they were not there. At this time (R1) told me that they were probably out in the road where he fell , then pointing to the intersection. At this time (responding Officer) was arriving on scene, as well as (local ambulance) I advised Medic on the injuries to (R1) and how he didn't know where he was, then recommending he get transported to (local emergency room /ER). I then went and checked the intersection (R1) pointed to to see if there were keys out there. No keys were found in the road, at the the intersection, or around the vehicle that (R1) was found in.</p> <p>Emergency Department Provider Notes dated 4/12/25 at 7:39pm documented, [AGE] year old male who presents to the emergency department for evaluation of a ground level fall. Reportedly the patient lives in the memory care unit at a local skilled nursing facility and escaped (from) the unit. He reportedly was running, tripped and fell on the street. Emergency Management System was called and the patient brought into ER for evaluation. Skin: Skin tear over left temporal region. Scattered abrasions over hands, wrists, and elbows bilaterally. No lacerations. The patients labs, EKG (Electrocardiogram) and imaging were reviewed and reveal no significant findings as read by the Radiologist. We will discharge him back to his skilled nursing facility.</p> <p>A Nurses Note dated 4/12/25 at 10pm, authored by V4, Licensed Practical Nurse/LPN, documented, Resident received back at facility via EMS (Emergency Management System); transferred from stretcher to bed. Resident is (alert and oriented to self) Speech is clear. Answers questions appropriately. Bilateral upper extremity strength equal. Vital signs stable. Left forehead laceration closed with surgical glue. Laceration site is clean and dry. Resident reports mild pain in head. Resident resting comfortably in bed. I called and spoke to (V11 - R1's POA) and updated on event. She verbalized understanding of resident condition today and will call with any questions or concerns.</p> <p>On 4/15/25 at 11:35am, V4 stated R1 returned from the ER about 10pm on 4/12/25. V4 stated when he returned, she notified V11 that R1 had gotten out of the building, had fallen and had been sent to the ER, received minor injuries, and was now back at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/19/25 at 8:40am, V11 stated on 4/12/25 she was called by a facility nurse, name unknown, sometime after 9pm who told her (R1) had got outside and he fell , he had just come back from ER, but he was ok. V11 stated she was extremely upset about staff not calling her when they first became aware of the elopement, nor did they provide the full details of the event. V11 stated, What if he would have gotten run over in the street? V11 stated she has been questioning the facility's ability to adequately supervise R1 and she has been looking for an alternative placement.</p> <p>A Change in Condition Policy dated February 2012 documented, It is the policy of (the facility) that resident change in condition will be assessed promptly and follow up activity will occur as appropriate and in a timely manner. 5. The resident's designated medical contact will also be notified. In certain circumstances, the change may warrant contacting clergy or other significant persons.</p> <p>A Resident Rights Policy dated 8/31/23 documented, The resident representative has the right to exercise the residents rights to the extent those rights are delegated to the resident representative.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619</p> <p>Based on interview, observation, and record review, the facility failed to prevent a cognitively impaired ambulatory resident (R1) from exiting the facility unwitnessed and without staff supervision for 1 of 3 residents reviewed for elopement in the sample of 3. This failure resulted in R1, unknown to staff, exiting the facility and walking approximately one block away, falling and sustaining a skin tear over his left temporal region and scattered abrasions over both hands, wrists, and elbows, and then entering a private citizens unlocked vehicle. R1 was treated at the local ER (emergency room) for the skin tears and released later that evening.</p> <p>The Immediate Jeopardy began on [DATE] between 6pm and 6:18pm when R1 exited the facility's Dementia Care Unit unsupervised, walked about a block away, fell in the street, gained access to an unlocked vehicle, and was then found by police, bleeding from the head and confused about his whereabouts. V1, Administrator, was notified of the Immediate Jeopardy on [DATE] at 3:32pm. The Surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.</p> <p>R1's Face Sheet documented an admitted [DATE] and listed Diagnoses including Alzheimer's Disease and Hypertensive Heart Disease with Heart Failure. R1's Minimum Data Set (MDS) dated [DATE] documented that R1 is severely cognitively impaired, wanders, and exhibits behaviors not directed toward others. The same MDS documents that R1 has no impairments in upper or lower body range of motion and requires partial to moderate assistance for walking.</p> <p>R1's current Care Plan documented a problem area, Problem start date: [DATE]. Resident is at risk for injuries due to exit seeking behaviors. Attempts to exit the building unattended. ELOPEMENT RISK. Approach includes: Re-direct as needed/cues; Notify all staff of residents tendency to seek exits; Diversional activities as tolerated; Check residents whereabouts; all with a start date of [DATE]. Staff to Initiate 30-minute checks, with start date of [DATE].</p> <p>R1's Elopement Evaluation date [DATE] documents R1 is cognitively impaired, poor decision-making skills, and/or pertinent diagnosis (Example, dementia, Organic Brain Syndrome, Alzheimer's, delusions, hallucinations, anxiety disorder, depression, manic depression, and schizophrenia). R1's evaluation documents R1 has a history or wandering (into unsafe area), makes statements that they are leaving and displays behavior(s) that may indicate an attempt to leave, body language etc., indicating an elopement may be forthcoming. R1's evaluation documents resident is at risk for elopement, elopement care plan initiated.</p> <p>A Power of Attorney (POA) Health Care form dated [DATE] listed V11 as R1's POA.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A Police Report dated [DATE] at 6:18pm documented, in part, On [DATE], I, (V6, Police Officer) was off-duty, when I viewed an older male sitting in the drivers seat of a Chevrolet SUV in the (name of street located 0.2 miles away from the facility) with what appeared to be blood coming from the left upper head area. As I went around the block to come back to the male subject, I called (local city) dispatch on what I viewed and kept them on the phone while I made contact with the male in the vehicle. Before approaching the vehicle, I gave the Illinois registration information to dispatch. Once at the vehicle, the male opened the drivers door, and I viewed scrapes on the palm of his right hand, skin tears that were open and bleeding, and a laceration on the outer left eyebrow area. I requested an ambulance come and check on the male, with dispatch toning out an ambulance to my location. At this time I hung up with dispatch and stayed with the male. While speaking with the male, I learned his name was (R1) and that he had fallen down in front of his vehicle. (R1) advised that he was just sitting in his car for a minute, but he was ready to go now. I viewed (R1) not to be responding correctly, and he did not seem to know where he was at. When I asked (R1) what his address was, he could not tell me and said that 'he lived on that street over there.' I asked (R1) why he was out of his vehicle and how he fell down, he advised 'that he was working on a house and was going home now.' At this time (R1) began reaching for the ignition, but I got his attention back to me advising him that I wanted him to get checked out by the medics before he goes home. (R1) then advised that this was ok, and began thanking me for stopping and helping him. I was then able to reach across the steering column and feel for ignition keys, but they were not there. At this time (R1) told me that they were probably out in the road where he fell , then pointing to the (name of two streets) intersection. At this time (name of responding Officer) was arriving on scene, as well as (name of local ambulance). I advised Medic (name of medic) on the injuries to (R1) and how he didn't know where he was, then recommending he get transported to (name of local hospital). I then went and checked the intersection (R1) pointed to to (sic) see if there were keys out there. No keys were found in the road, at the intersection, or around the vehicle that (R1) was found in. I then decided to contact (Name of Long Term Care Facility), being approx a block away and asked to speak to a supervisor. Once a supervisor got on the phone, I advised them who I was and asked if they knew a (R1). The supervisor advised that (R1) is a resident in their Alzheimer's wing. I advised that supervisor that (R1) is currently a block away from their facility, . being loaded up in an ambulance. I was then told that they would have someone there shortly. Approx 10 minutes later, two staff members arrived at my location and advised that they do not work on the wing where (R1) resides, but actually work on the behavioral wing, but were familiar with (R1). Both looked into the open rear door and advised that the male was in fact (R1). At this time one of the staff members asked who had found (R1), and I advised that I had. I explained to them who I was and who I worked for and that I would be making a report on the matter once I am back on duty. They understood and advised me that they would have their boss contact me on Monday ([DATE]). At this time that ambulance transported (R1) to the hospital to address his injuries, and I left the scene along with everyone else .On [DATE], . I then called (name of Long Term Care Facility) and spoke (to) Administrator (V1). I advised (V1) of who I was and who I work with, and how I was actually on scene this weekend when (R1) was found. (V1) advised that from what they have put together, (R1) was there for dinner and then left and was gone for approx an hour. I asked if their doors have alarms on them and he advised that they do and they are all operating and in working order. (V1) stated that there was a screen off from one of the windows on the front of the building and believe him to have exited out of this window .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Emergency Department Provider Notes dated [DATE] at 7:39pm documented, [AGE] year old male who presents to the emergency department for evaluation of a ground level fall. Reportedly the patient lives in the Dementia Care Unit at a local skilled nursing facility and escaped (from) the unit. He reportedly was running, tripped and fell on the street. Emergency Management System was called and the patient brought into ER (emergency room) for evaluation. Skin: Skin tear over left temporal region. Scattered abrasions over hands, wrists, and elbows bilaterally. No lacerations. The patients labs, EKG (Electrocardiogram) and imaging were reviewed and reveal no significant findings as read by the Radiologist. We will discharge him back to his skilled nursing facility.</p> <p>Nursing Progress Notes documented the following:</p> <p>[DATE] at 11:05am: (R1) is exit seeking this am (morning). He is going to the front door and then is redirected and then the backdoor. When I asked what he was doing he stated, I am trying to get home. I showed him his room and where he stays. He then said Bulls**t, and walked off. He requested a ride home from me. I declined and told him I did not drive. He walked away.</p> <p>[DATE] at 1:18pm: Resident continues to try to go out the doors and wanting someone to let him out. This writer was going into the medication room to get a few supplies and resident stated, Give me the keys. Politely said that is not possible. Resident said, Let me try the keys to get out. Politely again stated no that the keys are not used for that. Resident still wanted the keys but he did not ask again. Resident is currently in his room watching TV.</p> <p>[DATE] at 4:30pm: Resident has been slapping the tables, laughing out at random times, and trying to leave out the side doors. He is difficult to redirect and states he is trying to get to his car. I redirected resident to common area and provided him with vanilla pudding. Resident has been making sexual comments to other female residents and telling them he thinks they look real good and puckering his lips. Resident redirected to disengage conversation.</p> <p>[DATE] at 5:00pm: Resident continues trying to exit out the side door, it took this writer and CNA (Certified Nursing Assistant) to redirect resident from the door. Resident stated to me Hey, you look good and leaned in for a kiss. I politely declined and redirected resident to a chair near the nurse's station. Resident began yelling out and laughing. I asked resident to please stop yelling as this is upsetting the other residents.</p> <p>[DATE] at 8:57pm: Call received at approximately 1830 (6:30pm) from off duty police officer identified as (V6). States he has a gentleman who says his name is (R1). This nurse has advised there is a resident by that name. (V6) is advised this nurse will come to sight (sic) and identify resident. On arrival at location as directed by (V6). Individual is identified as (R1). Ambulance has arrived on scene prior to this nurse and (R1) is on gurney in sitting position with safety buckles on. Calm demeanor. Note head laceration left scalp et (and) minor abrasions on left f/a (forearm). Ambulance has advised will transport to (name of local hospital) for evaluation due to possible head injury. Reported to (V2, Director of Nurses) et have given report to (V1), Facility Administrator. Call received for report from (name of ER Nurse). Resident stable w (with) all x-rays negative . Resident has stated he was looking for someone when he was walking and he fell in the gravel somewhere. (V2) notified for update.</p> <p>[DATE] at 9:34am: Report received from (V3, Registered Nurse). Resident returning to facility from (name of local hospital). VS (Vital signs) stable. Awaiting arrival back to facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>[DATE] at 11:04pm: Resident up walking in hall. Redirected to bedroom. Resident assisted to bathroom. He states I'm not tired, I want a snack. I responded politely that he just ate a snack and should try to get some rest. Resident agreed and was assisted back to bed, shoes removed, and lying comfortably in bed. A/O x1. (alert only to self) Speech clear. Answers questions appropriately.</p> <p>[DATE] at 12:00am: Resident up ambulating in halls and common area. I observed him in the common area refrigerator; redirected resident to area next to nurse's station. Resident began asking for another snack; redirected patient back to room. Resident ambulated back to nurse's station complaining of a headache, he states his head pain is bad. I gave resident Tramadol 50mg (milligrams) for head pain. Resident then ambulated back to refrigerator and opened it and tried to grab an apple. I shut the door and discussed he cannot have a whole apple and redirected resident back to nurse's station. CNA helped resident back to bed and resident is lying comfortably in bed.</p> <p>A Neurological Observations Form documented that R1 received neurological checks, all of which were within normal limits, as follows:</p> <p>[DATE]: Every 15 minutes from 10pm to 11pm.</p> <p>[DATE]: Every 30 minutes from 11:30pm to 12am.</p> <p>[DATE]: Every hour from 1am to 3am.</p> <p>[DATE]: Every four hours from 7am to 11am.</p> <p>A 30 Minute Checks Sheet documented that R1's thirty-minute checks were initiated on [DATE] at 11:30am.</p> <p>An Event Report-Safety Events-Elopement dated [DATE] stated, Event date: [DATE] at 6:30pm. Where and when was resident found? (Name of street that runs behind the facility.) Did resident sustain any injury during the elopement period? Left scalp laceration and left forearm skin tear. Mental status, describe if necessary: As reported to this nurse, resident has participated in negative behavior throughout the day, opening doors, banging on furniture, agitating staff and other residents, loud yelling and exaggerated loud laughing. Interventions: As reported to this nurse, staff unable to redirect throughout shift, behaviors have escalated with louder yelling, looking for his keys to his car and motorcycle. Anger expressed over diet. Evaluation: Elopement Care Plan updated and door handle changed.</p> <p>A Daily Assignment Sheet dated [DATE] documented one nurse and 2 CNA's (V7 and V8) working on the Dementia Care Unit on the 7am to 7pm shift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An IDPH (Illinois Department of Public Health) final Investigation dated [DATE] documented, This is a Final Investigation regarding the report of a resident elopement on [DATE]. (R1) a [AGE] year old male with a diagnosis of Unspecified Dementia was located at the corner of (name of intersection) at the back side of the facility by an off-duty police officer at 6:35pm. (R1) was seen in the dining room of the (name of Dementia Care Unit) at 6:09pm by (V4, Licensed Practical Nurse) and at 6:15 by the CNA on duty. From investigations, (R1) had mentioned that day that he wanted to leave and find his vehicle. Redirection was given to (R1) according to Care Plan and behavior had stopped. (R1) opened door to front office door between 6:15 last time and 6:36 time phone call made to facility by off-duty police and climbed out of the window. The front office on that unit was unlocked and the screen was out of the open window. (R1) was sent to (name of local hospital) for evaluation. (R1) had a Power of Attorney, Medical Doctor, and police notified. Resident Care Plan updated upon return to include 30 minute checks. Resident remains in facility with no other incident.</p> <p>On [DATE] at 9:27am, V6 stated he was off duty and headed home when he observed an elderly man looking confused and with a bloodied head, sitting in a vehicle parked in front of a residence. V6 stated the man's foot was on the brake but there were no keys in the ignition. V6 stated the man was unable to answer most questions and it was very obvious he was cognitively impaired. V6 stated the man had skin tears on both arms, blood on his face from a laceration over his left eye, and abrasions to his right hand When asked about the injuries, he told V6 he fell . He stated to V6 he had been working on a house nearby and he was headed home. When asked where he lived he couldn't answer with an address but pointed and said, over there. V6 called EMS, and when they responded, one of the Paramedics recognized the man as R1, whom he had previously transported to the hospital. V6 stated he phoned the facility and asked for a supervisor, who confirmed R1 was a resident. V6 stated then 2 staff members responded to the scene and positively identified R1. V6 stated when he spoke to V1 on [DATE], V1 stated they had determined that R1 pushed out the screen of a window to elope.</p> <p>On [DATE] at 10:15am, V1 stated there is no video surveillance anywhere in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 11:35am, V4, Licensed Practical Nurse (LPN) stated she worked on the facility's Dementia Care Unit on [DATE] from 2pm to 10pm. V4 stated she had been told in report that R1 had been having increased behaviors. V4 stated from 2pm on, R1 displayed behaviors of verbal aggression, exit seeking, yelling for his keys, car, and motorcycle, yelling at and mocking other residents, and doing laps around the unit, pushing the exit doors and activating the alarms. V4 stated she had to block R1's attempts to elope by getting between him and the exits several times. V4 stated redirection with snacks, drinks, and diversion did not work at all. V4 stated she was working with 2 CNA staff and there was a lot to do with 25 residents on the unit, most of whom have behaviors, are incontinent, and require maximal assistance with ADL's (Activities of Daily Living). V4 stated after supper, at about 6:00pm, R1 was in the dining room and she gave him his scheduled medications. V4 stated she then had been sitting at the nurses station within eyesight of R1, and the 2 CNAs were doing a mechanical lift on another resident down the hall. V4 stated she left the nurses station to assist a resident and, The next thing she knew, V3, Registered Nurse, was telling her she needed to do a head count, because the police had found (R1) outside the facility. V4 stated she was surprised R1 eloped as all the exits are alarmed. V4 stated it is her understanding that apparently activity staff left an unlocked door to a small office next to the front exit, and when she and other staff checked the unit, they noticed the window in the office was open and the screen was out and laying on the ground. V4 stated she believes R1 is physically capable of climbing out a window, and it probably took R1 less than a minute to get out. V4 stated she did not have a key to that office, doesn't know who does, and has never tried to open it. V4 stated her shift ended at 10pm, which was approximately the time R1 returned from ER. V4 stated she stayed with R1 until he fell asleep at about 2am because upon his return he continued to have exit seeking behavior. V4 stated she contacted V11 (R1's POA) when R1 returned from ER and informed her R1 had gotten out of the facility, had fallen, was treated at the ER for minor injuries and had returned to the facility. V4 stated after the elopement, all residents at risk for elopement on that unit, which is the majority of them, are now on every 30-minute checks to be documented in the Elopement Binder. V4 stated if the office door had been locked, and/or if they had had another CNA or perhaps a Unit Aid, they could have provided increased supervision for R1 and he would not have eloped.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:10pm, V7, CNA, stated on [DATE] she worked 7am to 7pm on the Dementia Care Unit. V7 stated all shift, R1 was exit seeking, saying sexual things to and trying to grab staff, and asking for his motorcycle saying he was, Getting out of here. The off going shift said he had been displaying these behaviors on their shift also. V7 stated for redirection, she tried snacks, talking to R1 one to one, frequent toileting, his favorite TV shows, and playing music for him, but nothing worked. V7 stated R1 displays these behaviors often, and they fluctuate from day to day. V7 stated for the past couple of weeks, his behaviors have been worse. V7 stated on [DATE] she recalled seeing R1 after dinner sitting in the dining room at about 5:30pm. V7 stated at some point after 6pm, she heard other staff talking about R1 having eloped. V7 stated when it was discovered R1 eloped, she checked the unit and it was discovered that a small office used for storage had the door unlocked, the window was open and the screen had been pushed out. V7 stated she assumes R1 climbed out the window. V7 stated looking back, when R1 pushed on the exit doors on the north and south sides of the building, the alarms were working. V7 stated she does however think R1 has figured out that if you push on the alarmed doors they will open after 15 seconds, but stated they did not hear any door alarms going off when he was out of staffs sight. V7 stated the following day when she came to work, there was an elopement book that all elopement risk residents are to be charted on every 30 minutes. V7 stated having more staff could have prevented R1's elopement, even if it was a Unit Aid or an Activity Aid. V7 stated she feels R1's behaviors are aggravated by boredom. V7 stated multiple staff have told administration they need more help on the unit but are told the Corporation who owns the facility says they are not needed.</p> <p>On [DATE] at 11:25am, [DATE] at 8:45am, and [DATE] at 8:30am messages were left on V8, CNA 's voice mail, but the Surveyors calls were not returned.</p> <p>On [DATE] at 2:00pm, R1 was ambulating independently around the Dementia Care Unit, alert only to himself. When asked about the elopement, R1 said he did not remember.</p> <p>On [DATE] at 2:37pm, the shower room on the Dementia Care Unit's north hall was observed to have an unlocked door, and a double window, the right side of which was unlocked, with no screen and no devices to prevent the window to be raised to within approximately 4 inches of the full height. V5, Maintenance Director, who was present, stated R1 could have eloped from that window, but it egresses a courtyard with a locked gate, and no evidence had been found that the gate was left unlocked.</p> <p>On [DATE] at 2:39pm, the alarmed glass double door exit on the north hall, which has a keypad, was checked by the Surveyor, and it was noted that 15 seconds of pressure on both doors did not activate the alarm, but the doors could be pushed open after 15 seconds. The Surveyor called over V5, who was standing at the end of the hallway, and V5 pushed on the doors and confirmed the alarm was not working but the doors were automatically opening. V5 was also able to open the doors using the keypad. V5 stated he was not sure why alarms to the exit door were not working properly, and that he checks all the exits once a week, and it was in working order last time he checked it. V5 could not recall what date he had last checked the door. When the doors opened, a residential area with an intersection of two streets was observed, which V5 stated that was the area where the police had found R1. V5 stated he would fix the door as soon as possible. V5 stated it was possible R1 could have eloped from that exit if the alarm was not working.</p> <p>On [DATE] at 3:10pm, V1 was notified that the Surveyor had observed the above referenced issues with the Dementia Care Unit north exit door self-releasing but not alarming. V1 stated he would be consulting with V5 about it.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 11:05am, V1 stated on [DATE] at around 6:45pm, he was notified by V3 that R1 had been found by police less than a block away from the property. V1 stated he was told R1 had a laceration to the head and was being sent to ER. V1 stated he instructed staff to write down their statement of events and for V7 to inspect the building to see how R1 eloped. V1 stated a Complete sweep of the property, showed the door to the small office by the front entrance was unlocked, the window was open, and the screen was out. V1 stated on [DATE] at 1pm, V1 was at the facility for an Easter egg hunt, and he observed that the window where R1 allegedly eloped as being closed with the screen in it. V1 stated activity staff had been accessing the small office where some of the supplies were kept for the Easter egg hunt. and could have left the door unlocked. V1 stated he instructed V5 to put a self-locking handle on the door of that office, which was done on [DATE]. V1 stated staff are doing every 30-minute checks on all residents at risk for elopement on the Dementia Care Unit. V1 stated V9, Social Services Director, came to the facility on [DATE] and began reeducating staff on checking exits and windows and doing visual checks on elopement risk residents every 30 minutes.</p> <p>On [DATE] at 8:15am, the north hall double door exit on the Dementia Care Unit was checked by the Surveyor with V5. The alarm was still not working, but the doors did not release when pressure was applied. The keypad was working. V5 stated he, Messed with, the door the previous day but could not get the alarm to work. V5 stated he called the company that services the alarm doors, but they could not come out until the following week.</p> <p>On [DATE] at 2:25pm, V2, Director of Nurses, stated staff chart behaviors that are unusual for the resident on an Event Report document. V2 stated staff do not do behavior tracking, but chart behaviors that are usual for the resident in the Nurses Notes.</p> <p>On [DATE] at 11:27 A.M. V1 stated that R1 upon his return to the facility was on neurological checks, and that after the neurological checks were completed the facility started the 30-minute checks.</p> <p>On [DATE] at 1:40 P.M. R1 was observed standing at the end of the hallway on the Dementia Care Unit pushing on the north exit door, and then wandering into a resident room a few seconds later.</p> <p>On [DATE] at 1:43 P.M. R1 was observed standing at the exit which adjoins the Behavior Unit, pushing the buttons on the keypad.</p> <p>On [DATE] at 8:40am, V11 (R1's POA) stated on [DATE] she was called by a facility nurse, name unknown, who told her (R1) had got outside and he fell , he had just come back from ER, but he was ok. V11 stated she was extremely upset about staff not calling her when they first became aware of the elopement, nor did they provide the full details of the event. V11 stated she has been questioning the facility's ability to adequately supervise R1 and she has been looking for an alternative placement. V11 stated, It is way more likely he got out an exit than climbing out a window, though it is possible.</p> <p>On [DATE] at 11:40am, V10, Physician/Medical Director, stated he was on [DATE] of the elopement. V10 stated he has concerns that the facility may be understaffed, but stated he has no control over making decisions about staffing patterns.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's Door Alarm/System Check Logs for March and [DATE] documented the alarmed exit doors for both of the facility's buildings were being checked once weekly. The April Log documented the alarms were checked on [DATE] and in working order, were not checked when due on [DATE], but were again checked on [DATE] after the elopement occurred.</p> <p>An Elopement Prevention Policy dated [DATE] stated, It is the policy of (the facility) to provide a safe and secure environment for all residents. To ensure this process, the staff will assess all residents for the potential for elopement. Determination of risk will be assigned for each individual resident and interventions for prevention be established in the plan of care to minimize the risk for elopement. 11. Door alarms are checked daily by maintenance for function.</p> <p>On [DATE] at 3:00pm, when asked why V5 had not been checking the alarmed doors daily per facility policy, V1 stated he was unaware that this was the policy.</p> <p>A Safety and Supervision of Residents Policy dated [DATE] documented, 9. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual residents assessed needs and identified hazards in the environment. 10. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards or if there is a change in the resident's condition.</p> <p>The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy and correct the deficient practice as confirmed through observation, interview, and record review:</p> <p>R1 was placed on 30-minute checks which began on [DATE] at 11:30am. R1's Care Plan was updated to reflect elopement interventions on [DATE].</p> <p>On [DATE], V9 ensured the office door from which R1 was believed to have accessed a window to elope, was locked. On [DATE], V5 installed a self-locking doorknob, replaced the window screen and secured the window.</p> <p>All residents identified at risk for elopement care plans were updated with interventions, as well as the facility's Elopement Binder by V9 on [DATE].</p> <p>On [DATE], V5 installed a self-locking doorknob on the north hall shower room, and secured the window so as not to allow opening.</p> <p>On [DATE] at 4:01pm, V5 and V13, Corporate Regional Director, confirmed the north exit door did not automatically open with 15 seconds of pressure.</p> <p>On [DATE], V9 completed Elopement Assessments on all residents of the Dementia Care Unit.</p> <p>On [DATE], V14, Minimum Data Set Coordinator, completed a Care Plan audit on all residents of the Dementia Care Unit to ensure Care Plans addressed elopement risk.</p> <p>On [DATE], V13 reviewed the Resident Supervision Policy with no changes made.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE], V2 and V15, LPN/Assistant DON, completed staff education on resident supervision with all staff.</p> <p>On [DATE], V13 completed education for V5 regarding window and door security.</p> <p>V5 will complete window and door audits daily for one week, twice weekly for two weeks.</p> <p>V2 will complete a Facility Activity Audit to identify exit seeking behavior of residents daily for one week, twice weekly for two weeks, and weekly for 4 weeks.</p> <p>V9 will complete an audit of the Elopement Binder to ensure it is up to date according to Elopement Assessments daily for one week, twice weekly for two weeks, and weekly for four weeks.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>32619</p> <p>Based on interview and record review, the facility failed to adequately staff the Dementia Care Unit. This has the ability to affect all 25 residents living on that unit.</p> <p>Findings include:</p> <p>On 4/15/25 at 10:50am, V2, Director of Nurses/DON, stated she is the staff member responsible for scheduling nursing and CNA (Certified Nursing Assistant) staff. V2 stated the current census for the Dementia Care Unit is 25. V2 stated, We schedule one nurse and we try to schedule 2 CNA's on the Dementia Unit for both shifts, 7pm to 7am and 7am to 7pm, but sometimes it doesn't happen with CNA call ins.</p> <p>On 4/15/25 at 11:35am, V4, Licensed Practical Nurse/LPN, stated she works weekends on the 7am to 7pm shift on the Dementia Unit. V4 stated normally she works with 2 CNA's. V4 stated the unit is not adequately staffed as the majority of the residents are incontinent, several require a mechanical lift for transfers, several require 100% feeding assist, and many display behaviors. V4 also stated they do not have enough staff to provide one to one supervision for residents who require it.</p> <p>On 4/15/25 at 12:10pm, V7, CNA, stated she works the day shift on the Dementia Unit. V7 stated there is one nurse and generally 2 CNA's, which is not enough considering the level of care and supervision most require. V7 stated multiple staff have complained to administration that increased staff is needed but have been told the facility's corporate staff will not approve it.</p> <p>On 4/19/25 at 8:40am, V11, R1's Power of Attorney, stated when she visits R1 he often displays agitation and exit seeking behavior. V11 stated she often has difficulty finding staff to help her redirect R1 and to change R1 when he is incontinent. V11 stated at times staff will call and ask her to come to the unit as R1 is having behaviors, and V11 feels this is due to the unit not being adequately staffed and don't have time to closely supervise and redirect R1. V11 stated this is especially evident on the day shift on weekends.</p> <p>On 4/19/25 at 11:40am, V10, Physician/Medical Director, stated he has concerns that the facility may be understaffed, but stated he has no control over making decisions about staffing patterns.</p> <p>On 4/19/25 at 1pm, V12, CNA, stated she works the day shift in different areas of the facility. V12 stated when she works on the Dementia Unit, there are usually 2 CNA's and one nurse on day shift. V12 stated when their night shift relief arrives, at times there is only one CNA and they share one nurse with the Behavior Unit.</p> <p>On 4/19/25 at 2:50pm, V2 stated on the 7pm to 7am shift, there are 2 nurses on duty for the whole facility, with one nurse being assigned to the east building and one assigned to the west building (where the Dementia and Behavioral Units are located).</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Daily Assignment Sheets documented that on the following dates on the 7pm to 7am shift, there was one CNA working on the Dementia Unit and one nurse shared between the Behavior and Dementia Units: Wednesday 3/5/25, Saturday 3/29/25, Wednesday 4/2/25, Tuesday 4/15/25, Friday 4/18/25.</p> <p>A Staffing Policy dated November 2021 documented, The facility provides adequate staffing to meet needed care and services for our resident population and according to regulatory requirements. 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met and schedules adequate staff to meet or exceed individual state requirements are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan.</p> <p>A Daily Census dated 4/15/25 documented a total of 25 resident living on the Dementia Unit.</p>		